TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Weiss, James

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-15-3807-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we are seeking the balance owed to us."

Amount in Dispute: $265.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We contacted the provider and they changed the code to 99214 for date of service 1/5/15. Payment will be made accordingly."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2015	99204, 95886, 95913, A4556	$265.34	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee guidelines
   - 459 – This provider has already billed and been reimbursed for an initial office visit
   - 18 – Exact duplicate claim/service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - D00 – Based on further review, no additional allowance is warranted

- A19 – Upon further review, additional payment is warranted

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are physician services. The applicable rule 28 Texas Administrative Code §134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (yearly date of service conversion factor).

   - Procedure code 99214, (changed per respondent's position statement from original code of 99204) service date January 5, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.5. The practice expense (PE) RVU of 1.43 multiplied by the PE GPCI of 0.92 is 1.3156. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.822 is 0.0822. The sum of 2.8978 is multiplied by the Division conversion factor of $56.20 for a MAR of $162.86.
   - Procedure code 95886, service date January 5, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.92 is 0.3772. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.822 is 0.02466. The sum of 1.26186 is multiplied by the Division conversion factor of $56.20 for a MAR of $70.92 at 2 units is $141.84.
   - Procedure code 95913, service date January 5, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3.56 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3.56. The practice expense (PE) RVU of 1.6 multiplied by the PE GPCI of 0.92 is 1.472. The malpractice RVU of 0.16 multiplied by the malpractice GPCI of 0.822 is 0.13152. The sum of 5.16352 is multiplied by the Division conversion factor of $56.20 for a MAR of $290.19.
   - Procedure code A4556, service date January 5, 2015, represents a supply or equipment with reimbursement determined per §134.203(d). The fee listed for this code in the Medicare DMEPOS fee schedule is $13.48. 125% of this amount is $16.85.

2. The total allowable reimbursement for the services in dispute is $611.74. This amount less the amount previously paid by the insurance carrier of $896.64 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.